STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF REGISTERED NURSING
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Ruth Ann Terry, MPH, RN, Executive Officer

NURSING PRACTICE COMMITTEE MEETING
MEETING MINUTES

DATE: March 20, 2008

TIME: 2:00 PM – 3:00 PM

LOCATION: Hilton Los Angeles Airport
5711 West Century Blvd.
Los Angeles, CA 90045
(310) 410-4000

COMMMITTEE MEMBERS PRESENT:

Susanne J Phillips, RN, MSN, APRN-BC, FNP, Chair
Grace Corse, RN
Carmen Morales-Board, RNC, MSN, FNPC
Elizabeth O. Dietz, EdD, RN, CS-NP

OTHERS PRESENT:

Janette Wackerly, MBA, RN NEC Liaison
Ruth Ann Terry, MPH, RN Executive Officer BRN
Heidi Goodman, Assistant Executive Officer
Louise Bailey Med, RN SNEC
Maria Bedroni EdD, RN, SNEC
Miyo Minato, MN, RN, NEC
Badrieh Caraway, MS, RN, NEC
Katie Daugherty, MSN, RN,
Donna Fox RN CA Nurses Association
Geri Nibbs, MN, RN NEC
Alice Takahashi MSN, RN, NEC
La Francine Tate, Board President

Susanne J Phillips, Chair, opened the meeting at 2:10 pm with introduction of the committee

Open Forum:

Donna Dorsey Fox, CA Nurses Association Public Comment:

I would like to thank the committee of Nursing Practice, as well as the BRN Board members and BRN staff, for producing a clear regulation regarding the Administration of Insulin in Schools by unlicensed personnel.

Your clarity and ongoing work to fight this threat to the California Nursing Practice Act is consistent with the Nursing Practice Committee Goals and Objectives of 2008-2009.

Since this is the Nursing Practice Committee and not the Legislative Committee, I would like to remind everyone that your attention continues to be needed because currently this threat to the California Nursing Practice Act exists in each of the three branches of government.

Approve/Not Approve: Minutes of January 17, 2008
MSC: Dietz/Morales approve the minutes of January 17, 2008

1.0 Approve/Not Approve: Practice Committee Goals and Objectives 2008-2009

MSC: Dietz/Morales Approve the Committee Goals and Objective 2008-2009

2.0 Committee Liaison described that the only substantive change is to Goal 2, Promoting patient safety as an essential and vital component of quality nursing care.

2.1 Engage and dialog with recognized national experts in supporting patient safety in what individuals and organizations have done and what remains to be done. For example just culture and root cause analysis, failure mode and effective analysis, human factor and systems factor.

2.2 Monitor patient safety activities as a component of quality nursing care such as health care errors, competency, patient outcomes, stakeholders, nursing shortages, ethics, lifelong learning, nursing standards, licensure, safety legislation, magnet hospitals

3.0 Information Only:
(a) California HealthCare Foundation, January 2008: Scope of Practice Laws in Health Care: Rethinking the Role of Nurse Practitioners

(b) The Center for the Health Professions, UCSF, 2007, Overview of Nurse Practitioner Scopes in the United States-Discussion.

(a) Scope of Practice Laws in Health Care: Rethinking the Role of Nurse Practitioners.

Key Findings of the Survey:

- NPs are registered nurses with advanced clinical training. They serve as primary care providers in a broad range of acute and outpatient settings, such as pediatrics, internal medicine, anesthetics, geriatrics, and obstetrics
- NPs began to practice in the 1960's, in response to a nationwide physician shortage. Today, there are an estimated 145,000 NPs nationwide, and 13,649 in California.
- The 50 states and the District of Columbia have individual control over the laws that govern NP scope of practice. This has resulted in wide state-by-state differences in the types of services that NPs can deliver to their patients.
- These differences in scope of practice may slow the uniform expansion of NP services, prohibit NPs from providing the care for which they are trained, and hampered the use of NPs in improving access and controlling health care costs.
- California is roughly in the middle, nationwide, in NP practice autonomy and independence. NPs must collaborate with physicians and develop joint, written protocols that cover all major elements of the NP practice.
- California NPs may diagnose, order tests and durable medical equipment, refer patients, and "furnish" or "order" drugs, but only according to that protocol. There is a cap of four drug prescribing NPs per physician.
- Six states---Alaska, Arizona, New Hampshire, New Mexico, Oregon, and Washington—have NP scopes of practice that are among the nations most expansive. In these states, NPs practice autonomously, without physician oversight, and prescribe drugs without physician involvement.

The conclusion of this report:

Today there is a great deal of discussion in health policy circles, in California and across the country, of an impending physician shortage. In many ways, this current debate mirrors the events of the 1960's which spawned the initial development of the nurse practitioner.

Despite wide state-by-state differences in practice authorities, NPs deliver comprehensive medical services in a variety of settings and specialties, which are largely comparable to those provided by physicians, both in scope and medical outcomes.

The reappearance of the physician shortage issue suggests that the efficiency, accessibility, and quality of the health care system could benefit from the increased inter-professional collaboration, and be revised models for delivery of medical services that employ uniform, shared scopes of practice among providers

And with California possibly poised to overhaul its system of health care coverage, a review of the nurse practitioner's role in that system may become a part of the plan.

California Health Care Foundation, January 2008

(b) The Center for the Health Professions, UCSF. Overview of NP Scopes of Practice in the US---Discussion. Executive Summary

Nurse Practitioners (NPs) are registered nurses who are prepared beyond initial nursing education in a NP program to provide primary care directly to patients. The profession originated in the mid-1960s in response to shortage of physicians (MDs). NP education requirements, certification mechanisms and legal scopes of practice are decided at the state level and vary considerably.

NP scopes of practice vary widely among the states:

- Eleven states permit NPs to practice independently, without physician involvement
- Twenty-seven permit NPs to practice in collaboration with an MD. Collaboration definitions vary, but written practice protocols are often required
- Ten states require MD supervision of NPs
- NPs in all states may prescribe, but MD involvement is generally required to varying degrees. Additional limitations such as 72-hour or 30-day supplies may apply.
- Specific practice authorities are sometimes articulated although states may require MD involvement for any task: 44 states explicitly authorize NPs to diagnose (sometimes limited to a nursing diagnosis): 33 states explicitly authorize NPs to refer; and 20 states explicitly authorize NPs to order tests.

Education and certification requirements vary:

- Forty-two states require national certification as part of NP licensure.
- Just over half of the states require NPs to be prepared with a master's degree, while some states only require completion of a few months of post-RN education

Implications of current policy:

- Preventing professionals from practicing to the full extent of their competence negatively affects health care costs, access and quality.

- NP practices are impeded by scope of practice laws, financing and reimbursement mechanisms, malpractice insurance policies and outdated practice models.
- The professions and the public are ill-served when practice authorities differ dramatically among states.

Policy options to consider:

- Continue trend to expand NP scope of practice to match competence.
- Adopt uniform scope of practice laws to reduce variability among states
- Increase number of NP programs to reflect growing demand for primary care

UCSF Center for the Health Professions, 2007: Sharon Christian, JD, Catherine Dower, JD and Ed O'Neil, PhD, MPA, FAAN.

4.0 **Information Only**: The Center for American Nurses Calls For an End to Lateral Violence and Bullying in Nursing Work Environments – New position statement offers information and recommended strategies

Statement of Position

Lateral violence and bullying have been extensively reported and documented among healthcare professionals with serious, negative outcomes for registered nurses, their patients, and health care employers. These disruptive behaviors are toxic to the nursing profession and have a negative impact on retention of quality staff. Horizontal violence and bullying should never be considered normally related to socialization in nursing nor accepted in professional relationships. It is the position of the CENTER for American Nurses (The CENTER) that there is no place in a professional practice environment for lateral violence and bullying among nurses or between healthcare professionals. All healthcare organizations should implement a zero tolerance policy related to disruptive behavior, including a professional code of conduct and educational and behavioral interventions to assist nurses in addressing disruptive behavior. (Approved February 2008)

The CENTER in its statement defines bullying and lateral violence, as disruptive behavior, culture of safety, workplace bullying and verbal abuse.

The CENTER adopted a position statement which includes recommended strategies that nurses, employers/organizations, continuing education and academic programs and nursing researchers can employ to eliminate lateral violence and bulling.

The Center for American Nurses is a national professional nursing organization that educates, equips, and empowers nurses to advocate for themselves, their profession, and their patients. The Center offers evidence-

based solutions and powerful tools to navigate workplace challenges, optimize patient outcomes, and maximize career benefits. Established in 2003, The Center partners with its 42 organization members, comprised of over 47,000 registered nurses nationwide, to develop resources, strategies, and tools to help nurses manage evolving workforce issues and succeed in their careers. Additional information about the Center can be found at www.centerforamericannurses.org.

5.0 **Information Only**: CMS February 8, 2008: Hospitals – Revised Interpretive Guidelines for Hospital Conditions of Participation (Medicare)
The attached are the interpretive guidelines that correspond with the regulatory changes published November 27, 2006 amending Hospitals Conditions of Participation pertaining to requirements for history and physicals examination; authentication of verbal orders; securing medications; and post anesthesia evaluation.

The interpretive guidelines are important for registered nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives and certified nurse anesthetists.

The following is a brief report and full text can be reviewed in the attachment to this agenda item.

History and Physical: § 482.22 (c) (5) (i)

Physician: Requirement for medical history and physical examination and purpose of the H&P. Medical Staff bylaws must address requirement for H&P 30 days prior to or 24 hours after hospital admission but prior to surgery or a procedure that requires anesthesia

Other qualified licensed individuals are those practitioners who are authorized in accordance with their State scope of practice laws or regulations to perform an H&P and who are formally authorized by the to conduct an H&P. Other qualified licensed practitioners could include nurse practitioners and physician assistants.

Nursing Services: § 482.54 (b) (1)

The hospital must provide nursing services 24 hours a day, 7 days a week. LPN can provide nursing services if a RN, who is immediately available for the bedside care of those patients, supervises care.

Exception: § 488.54 (c) sets forth certain conditions under which rural hospitals of 50 beds or fewer may be granted a temporary waiver of the 24 hour registered nurse requirement by the regional office.

Influenza and pneumococcal polysaccharide vaccines: § 482.23 (c) (2)

With the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accord with State law, and who is responsible for the care of the patient as specified under § 482.12 (c)

Nurse Practitioners and Physician Assistants responsible for the care of specific patients are also permitted to order drugs and biologicals in accord with delegation agreements, collaborative practice agreements, hospital policy and State law.

Note: If a hospital uses other written protocols or standing orders for drugs or biologicals that have been reviewed and approved by the medical staff, initiation of such protocol or standing orders requires an order from the practitioner responsible for patient care.

Hospitals are encourage to promote a culture in which it is not only acceptable, but also strongly encouraged, for staff to bring to the attention of the prescribing practitioner questions or concerns they have regarding orders. Any questions about the order for drugs or biologicals are expected to b e resolved prior to the preparation, or dispensing, or administration of the medication.

Verbal Orders: § 482.23 (c) (2) (i)

Verbal orders, if used, must be used infrequently. This means that the use of verbal orders must not be a common practice. Verbal orders pose an increased risk of miscommunication that could contribute to a medication or other error, resulting in a patient adverse event. Verbal orders should be used only to meet care needs of the patient when it is impossible or impractical for the ordering practitioner to write the order or enter the order into a computer (in case of a hospital with an electronic prescribing system) without delay of treatment. Verbal orders are not to be used for the convenience of the ordering practitioner.

Hospitals are expected to develop appropriate policies and procedures that govern the use of verbal orders and minimize their use. **CMS expects nationally accepted read-back verification practice to be implemented for every verbal order.** (71 FR 68680)

Verbal orders must be clearly communicated. All verbal orders must be immediately documented in the patient's medical record and signed by the individual receiving the order. Verbal orders should be recorded directly onto an order sheet in the patient's medical record or entered into the computerized order entry system.

Accepting Verbal Orders: § 482.23(c) (2) (ii)

When verbal orders are used, they must only be accepted by persons who are authorized to do so by hospital policy and procedure consistent with Federal and State laws.

Patient medical record entries: § 482.24 (c) (1)

All patient medical record entries must be legible, complete, dated, times and authenticated in written or electronic form by person responsible for providing or evaluating the services provided, consistent with hospital policies and procedures.

Authenticated verbal orders: § 482.9 (c) (1) (iii)

All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours.

Drugs and biologicals: § 482.25 (b) (2) (i)

All drugs and biologicals must be kept in a secure area, and locked when appropriate.

(71FR 68689) This regulation gives hospitals the flexibility to integrate patient self-administration of non-controlled drugs and biologicals into their practices as appropriate.

Pre-anesthesia evaluation: § 482.51(b) (1)

The pre-anesthesia evaluation must be performed within 48 hours prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. At a minimum, the pre-operative anesthetic evaluation of the patient should include:

- Notation of anesthetic risk:
- Anesthetic drug and allergy history:
- Any potential anesthesia problems identified
- Patient's condition prior to induction of anesthesia

Post-anesthesia evaluation: § 482.52 (b) (3)

A post-anesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services. In accordance with § 482.52 (a) anesthesia must be administered only by:

- A qualified anesthesiologist
- A doctor of medicine or osteopathy (other than an anesthesiologist)
- A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law
- A certified registered nurse anesthetist (CRNA), who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or

- An anesthesiologist's assistant who is under the supervision of an anesthesiologist who is immediately available if needed.

6.0 Information Only: Reorganization of Nurse Practitioner Information on BRN website

Staff Liaison requested this item be deferred until the next meeting of the committee.

Open Forum: No further public input

The Practice Committee was adjourned at 2:30 pm by Chair Susanne J. Phillips

Submitted by:

Janette Wackerly RN

Janette E. Wackerly, RN Liaison

Approved by:

Susanne J. Phillips

Susanne J. Phillips, RN, Chair